ture. After the peritoneal toilet has been completed a pocket is made by blunt dissection between the peritoneum and the under surface of the rectus muscle, on either one or both sides of the incision, according to the number of grafts to be used. The ovaries are then carefully inspected and areas of cystic degeneration are culled out after which the remainder is cut into disks 2 x 2 x ½ cm. and from one to three of these disks transplanted into the already prepared pockets. No sutures are used to hold the grafts in place. The abdominal wall is then closed in the usual manner.

Radiation Versus Surgery in the Treatment of Uterine Cancer.—The working rules that have been adopted by CROSSEN (*Jour. Missouri State Med. Assn.*, 1922, 19, 55) are that in the advanced inoperable cases as well as in the borderline cases of uterine cancer, radium is our most effective remedy. The palliative effect is nothing short of wonderful. The enlarged carcinomatous cervix with its bleeding papillary masses melts away as if by magic and the cavity closes, largely or entirely by granulation. But it should be remembered that radium is two-edged and may do as much harm by causing excessive scar tissue contraction or actual stimulation of the cancer cells as it may do good, consequently its use requires decided caution. It is hoped that in time the curative effects of radium may be extended to the limits of the pelvis, but that ideal has not yet been attained. In some extensive cases the cancer is completely eliminated by the radium; this result is attained, however, in only a small proportion of the cases. It may be hoped for but it is so infrequent in the classes of cases under consideration that the remedy must be presented to the patient as essentially a palliative measure, with only a possibility of cure. It is advisable to employ also deep roentgen-ray therapy to affect the cancer cells lying beyond the effective reach of the radium, but even this combination must be classed generally as palliative rather than curative. In clearly operable cases, that is, in those early cases apparently still confined to the uterus, Crossen feels that immediate removal of the uterus and adjacent tissue likely to be involved is the safest plan. Theoretically we should be able to cure these patients with radium with as great certainty and with far less danger than with the knife; but so far the actual results in cancer of the uterus do not justify displacement of the knife by radium in these early cases. In something over one thousand collected cases of carcinoma of the cervix treated by radium five years previous to the reports, about 20 per cent were cured—approximately the same percentage as by radical operation. When the cases were divided into classes it was found that more of the advanced and borderline cases were cured by radium than by operation, while of the early operable cases the percentage of cures by radium (31 per cent) fell decidedly below that by operation (40 to 45 per cent). We know what can be done with the knife in the individual case but we do not know the extent of the effectiveness of radium in an individual case until it is tried in that case and in the time required for trial by radium the chance of cure by operation slips away. In order to give the patient the best chance of cure in these early cases, it is advisable to employ both radium and operation. First give a heavy dose of radium, the same as though depending on it to effect a cure, then within a week or ten days do the

radical operation. The operation should be carried out within a short time after the radium treatment because later the radium treatment may have caused such marked connective tissue changes as to increase very decidedly the difficulties and hazard of the operation. This plan of treatment for the early case is based on the assumption that the patient is a good operative risk. If the patient has some serious complication making her a poor operative risk, then her best chance of survival cancer-free may be through radium without operation. The decision for or against operation and of the extent of operation, turns on a balancing of the hazards pro and con—the hazard of operation, the chance of failure of radium to kill the cancer cells in that individual, and the chance of metastasis near and far. On account of the latter danger, it is advisable to supplement the other treatment by deep roentgen-ray treatment.

Urethral Stricture in Women.—Stricture of the urethra in women is a condition which is very often overlooked, according to STEVENS (*Cal. State Jour. Med.*, 1922, 20, 51) although it may be responsible for marked functional and organic disturbances in the genito-urinary tract in this sex. It is a generally accepted idea that strictures of the female urethra are very uncommon. While this is true so far as the lumen of the canal is concerned, strictures at the meatus on the other hand are frequently encountered. As the female bladder is especially sensitive to reflex influences, marked subjective symptoms are often produced by comparatively slight obstructions. It must be remembered however, that these symptoms may be partly due to the accompanying urethritis or trigonitis. Frequent urination is the most common symptom of which these patients complain. The next most common symptom is pain which is referred to the urethral or bladder regions. The diagnosis is best made by means of the olive-tipped bougie. The majority of these strictures should be treated by means of gradual dilatation, absorption of the constricting exudate being best promoted by this procedure. In the presence of scar tissue however, meatotomy, internal urethrotomy, or external urethrotomy with resection of the scar tissue is often indicated. The symptoms improve, as a rule after two and disappear after five dilatations, recurrence being very unusual if treatment is not too abruptly discontinued.

This subject has also been carefully presented by WYNNE (*Surg. Gynec. and Obst.*, 1922, 34, 208), who states that the great majority of strictures are single, although multiple ones have been reported; and although the stricture may be located in any part of the urethra, the external meatus and anterior portion are the favorite sites. He classifies strictures as traumatic, inflammatory, neoplastic, congenital, senile and unknown, which terms are self-explanatory. The onset is usually gradual and the course progressive. In some cases the only symptoms noted by the patient are the small stream voided and the length of time required for the act of voiding, but in the great majority of cases there is also some degree of dysuria. The diagnosis is made by examination with sounds or, preferably, olive-tipped or bulbed bougies as advised above by Stevens. In certain cases the strictured area can be felt through the vagina. The endoscope is necessary for a complete examination. Wynne treats these patients by gradual dilatation of the